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Stigmatisation as a Public Health Tool against Obesity — A Health and Human Rights Perspective

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Abstract

The right to health is recognised in human rights law and is also part of the catalogue of patients' rights. It imposes a duty on governments to put in place a system of health protection making it possible for individuals to enjoy the highest attainable standard of health. However, disease patterns are constantly changing, and more and more attention is being paid to so-called lifestyle diseases. Individuals may expose themselves to health threats due to personal choices like eating and smoking habits, and this raises the issue of the individual's obligation with regard to ill health. Hence, is there not only a right to health but also a duty to be healthy? Using obesity as an example, and based on a cross-disciplinary research project, the article analyses selected European and national public health policy papers to see how individual rights and duties are framed and to analyse the use of stigmatisation as a public-health strategy from a health and human rights perspective.

Keywords

health and human rights – public health – life-style diseases – obesity – right to health – stigmatisation

1 Introduction¹

The right to health is recognised in human rights law² and is also included in the catalogue of patients' rights.³ It has a very broad scope, as is clearly

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1 This article is based on collaboration with a group of colleagues in two interdisciplinary projects at the University of Copenhagen: the UNIK project Food, Fitness and Pharma funded

illustrated by the interpretation promoted by the UN Committee on Economic, Social and Cultural Rights, This emphasizes that it is

... an inclusive right extending not only to timely and appropriate health-care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.⁴

In addition, the right to health is also closely linked to other health related rights including the right to life, the right to privacy, the right to non-discrimination and the right not to be exposed to inhuman and degrading treatment.⁵ Where the individual is the rights holder, States are duty-bearers. Governments are obliged not only to respect, but also to protect and fulfil the right to health. Taking the broad spectrum of health aspects into consideration, this is certainly a demanding task, which is challenging to fulfil.

Consideration for population health is, however, not only an obligation and a burden for governments, it is also an important societal interest. An unhealthy population may turn out to be a heavy economic burden, and good levels of health in the population are generally seen as vital to ensure productivity and economic growth.⁶ To that end public health policies can serve to ensure good population health, and such policies may go hand in hand with an individual

by the Ministry of Education, and the Governing Obesity project, funded by the Copenhagen University Excellence Programme. I wish to acknowledge the immense stimulus and inspiration I have received from this group. The usual disclaimer applies.

- 2 See e.g. UN, *International Covenant on Economic Social and Cultural Rights* (ICESCR), Article 12, UN, *Convention on the Elimination of Discrimination of Women* (CEDAW), Article 12, UN, *Convention of the Right of the Child* (CRC), Article 24, UN, *Convention on the Right of Persons with Disability* (CRPD), Article 25, Treaty of the Functioning of the European Union (TFEU), Article 168, and EU Charter on Fundamental Rights, Article 35.
- 3 See e.g. WHO, *A Declaration of the Promotion of Patients' Rights in Europe* (1994), Article 5, and Council of Europe, *Convention on Human Rights and Biomedicine*, Article 3.
- 4 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, *The right to the highest attainable standard of health* (Art. 12), U.N. Doc. E/C.12/2000/4 (2000), Section 1.1.
- 5 B. Toebes, 'The Right to Health and Other Health-Related Rights', in: B. Toebes, M. Hartlev, A. Hendriks and J. R. Hermann (eds.), *Health and Human Rights in Europe* (Cambridge: Intersentia, 2012), pp. 88-110.
- 6 T.H. Tulchinsky and E.A. Varavikova, *The New Public Health* (Burlington, MA: Elsevier Academic Press, 2nd ed. 2009), pp. 407-408.

right to health and can be seen as a means of complying with the obligation to protect and fulfil an individual right to health. However, it may also turn out that the interest of society in the good health of the population collides with the individual's interest in living a life in accordance with one's own preferences, whether healthy or unhealthy and risky, and this may provoke the question of whether there is not only a right to health, but also a 'duty' to be and stay healthy, and which measures governments legitimate may use to push for better population health.

The aim of this article is to analyse, from a health and human rights perspective, how public health strategies address so-called lifestyle diseases and conditions. Obesity will be used as an example to study the way individual rights and duties are framed and to explore the measures used to promote a healthier lifestyle. An important aspect will be to investigate whether public health policies, intentionally or unintentionally, make use of stigmatisation as a tool to trigger lifestyle changes, and if so, whether such stigmatisation is justified seen from a health and human rights perspective.

2 The Obesity Challenge and its Causes

For many years the fight against communicable diseases was the primary concern for WHO and many national health authorities. This has changed in the last fifteen years, when non-communicable diseases have turned out to be the new global health challenge.⁷ Among non-communicable diseases obesity has been highlighted by a number of international organisations to be one of the major health issues at the beginning of the 21st century. OECD estimates that more than half of the adult population of the EU are overweight and that the number of obese persons is increasing and amounts to approximately 17% in the EU.⁸ This development has been described as a global epidemic, which gives rise to major health and economic concerns; and WHO, OECD and the EU, as well as national governments, have developed special public-health policies and strategies to deal with the challenge.

⁷ See e.g. WHO, *Global Strategy for the prevention and control of noncommunicable diseases*, 53rd World Health Assembly, A53/14m 2000.

⁸ F. Sassi, *Obesity and the Economics of Prevention: Fit not Fat* (OECD, 2010) Chapter 2, and OECD, *Health at a Glance: Europe 2012* (OECD Publishing, 2010). Retrieved April 2014: http://dx.doi.org/10.1787/health_glance. Overweight is defined as a BMI of 25-29.9, and obesity as a BMI ≥ 30 .

The causes of obesity are at the same time very simple and very complex. Put simplistically, overweight and obesity is a result of a surplus of calories within the energy balance. If an individual consumes more calories than he or she uses, this will over time result in overweight. Based on this basic perception, one may assume that it should also be easy to get rid of surplus kilograms simply by eating less and being more physically active. Unfortunately, the reasons why individuals produce a surplus of calories are more complex. Here we also have to consider the environmental, socio-economic and cultural circumstances. A number of factors, including urban planning, the availability of food products, dietary knowledge and socio-economic status, have an impact on the individual's option to live a healthy life in terms of diet and physical activity. Genetics may also influence the development of overweight and obesity. Consequently, it is important to acknowledge the variety and complexity of the causes of obesity to draw up effective and well-balanced public health policies in this area.

3 Public Health and Human Rights

The relationship between public health and human rights has been subject to academic attention for many years. In some respects, public health and human rights are mutually supportive. The right to health recognised in human rights law promotes public health efforts when stressing States' obligations not only to respect but also to protect and fulfil the right to health and to ensure conditions under which individuals can lead a healthy life and enjoy the highest attainable standard of health.

However, governments' efforts to ensure a high level of health may also collide with the individual's human rights. There is clearly a tension between the collective approach of the public health community in its focus on societal benefits as opposed to the individual rights-based approach favoured by the human rights community. As pointed out by Jonathan Mann and colleagues, 'It is essential to recognize that in seeking to fulfil each of its core functions and responsibilities, public health may burden human rights'.⁹

This tension is very visible in clear-cut cases such as coercive vaccination programs and detention in cases of epidemics.¹⁰ Indeed, the history of combatting communicable diseases is loaded with examples of how restrictions on

9 J. Mann et al., 'Health and Human Rights', *Health and Human Rights* 1(1) (1997) 7-23.

10 J. Dute, 'Communicable Diseases and Human Rights', *European Journal of Health Law* (11) (2004) 45-53.

the few may serve the good of the many. Such cases raise clear human rights concerns, as personal liberty and the right to self-determination are recognised in human rights law, and interventions based on public health concerns must comply with these rights.¹¹ In general, human rights law is open to integrating public health concerns in a balancing of rights. The Syracuse principles accepts such concerns as a justification for derogating from civil and political rights, and Article 8(2) of the European Convention for Human Rights, could be mentioned as another example, explicitly recognising 'protection of health and morals' as a possible justification for interfering in individuals' right to private and family life.¹²

Even though these examples demonstrate clearly the human rights aspects of public health interventions, human rights and public health have to a large extent lived separate lives for many years, and the link between the two did not attract serious attention before the HIV/AIDS epidemic exposed (uncovered) human rights concerns generated by public health policies. Public health strategies regarding HIV and AIDS provoked a debate in the 1980s about public health and human rights, which brought both access to medicine and the risk of stigmatisation and discrimination on to the public health agenda. This raised the question of whether it was justified to expose individuals to stigmatisation in pursuit of the greater public good, and it was stressed that vulnerability is itself a risk factor when it comes to exposure to HIV.¹³ However, even though human rights were introduced as a concern into HIV/AIDS public health policies, it was still to a large degree based in public interest considerations. One of the key arguments for paying attention to human rights, such as the right to privacy and non-discrimination, was the interest in ensuring trust in preventive programs and the fact that fear of discrimination may prevent individuals from being tested and included in preventive initiatives.¹⁴

The human rights aspects of HIV/AIDS policies were not as clearly addressed in human rights law, as is the case with detention and coercive treatment based

11 Toebe, *supra* note 5, pp. 101-102; M. Hartlev, 'Patients' rights', in: B. Toebe, M. Hartlev, A. Hendriks and J.R. Hermann (eds.), *Health and Human Rights in Europe* (Cambridge: Intersentia, 2012), pp. 125-127.

12 UN, *Economic and Social Council, Syracuse Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, U.N. Doc. E/CN.4/1985/4, Annex (1985). See also ECtHR, *Enhorn v. Sweden*, application no. 56529/00.

13 Mann et al., *supra* note 9, 20-21; and R. Bayer, 'Stigma and the ethics of public health: not can we but should we', *Social Science and Medicine* 67 (2008) 463-472.

14 J. Mann and D. Tarantola, 'Responding to HIV/AIDS: a historical perspective', *Health and Human Rights* 2(4) (1998) 5-8; and S. Gruskin, E.J. Mills and D. Tarantola, 'History, principles and practice of health and human rights', *The Lancet* 370 (August 4) (2007) 449-455.

in public health considerations. But awareness about privacy protection and the risk of discrimination was raised, demonstrating that even less severe interventions may have an impact on the rights of the individual. The transfer of the disease burden from communicable to non-communicable diseases, have also called for different measures than the coercive measures available for targeting communicable diseases, and thus served to alleviate the tension between public health and human rights.¹⁵

All in all, public health and human rights may support each other in ensuring good health for the individual and the population, but health interventions may also involve violation of human rights. Consequently, human rights concern needs to be reflected in public health policies, and since the discussion about the link between public health and human rights was initiated in the 1980s, it has been observed that human rights seems gradually to have become a more integrated part of public health policies.¹⁶ The human right sensitivity of public health policies, however, still needs attention, and will be subject to discussion below.

4 Stigmatisation, Public Health and Human Rights

4.1 *Stigmatisation*

As explained above, the HIV/AIDS epidemic raised concerns about stigmatisation. Before looking more closely at stigmatisation in public health and asking how this could be assessed from a human rights perspective, it is necessary to arrive at a perception about stigma as a social phenomenon. In the sociological literature stigma relates closely to power and inequality. Those with power can deploy it deliberately towards other, often vulnerable persons. However, it is not the use of power in itself which creates stigmatisation: it is the purpose for which power is used which is important. In Ervin Goffmann's book on stigma, he defines stigma as a deeply discrediting attribute, which reduces the bearer 'from a whole and usual person to a tainted, discounted one', and he describes how stigma in general terms can be understood as a process of dehumanising,

15 S. Gruskin and D. Tarantola, 'Health and human rights' in: J.M. Mann, M.A. Grodin, G.J. Annas and S.P. Marks (eds.), *Perspectives on Health and Human Rights* (New York: Routledge, 2005), pp. 3-57. See also H. Nygren-Krug, 'A Human Rights-Based Approach to Non-Communicable Diseases', in: A. Clapham and M. Robinson (eds.), *Realizing the Right to Health*, Swiss Human Rights Book, vol. 3 (2009), pp. 263-276.

16 B. Toebes, 'Introduction', in: B. Toebes, M. Hartlev, A. Hendriks and J. R. Hermann (eds.), *Health and Human Rights in Europe* (Cambridge: Intersentia, 2012), pp. 1-19.

degrading, discrediting and devaluing people in certain population groups, often based on a feeling of disgust.¹⁷ Link and Phelan take a slightly broader approach.¹⁸ They hold that stigma exists when elements of ‘labelling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows the components of stigma to unfold’.¹⁹ Labelling occurs when people distinguish and label human differences, and this develops into stereotyping when linked to undesirable characteristics by dominant cultural views. As a third component, labelled persons are placed in distinct categories in order to separate ‘them’ from ‘us’. The fourth component relates to labelled persons’ experience of status loss and discrimination. Link and Phelan stress that stigma exists as a ‘matter of degree’ and that all the components may demonstrate stronger or weaker elements of stigma.²⁰ As I will discuss further below, this may be of importance in accessing the legal justifiability of using stigma as a public health tool.

Link and Phelan emphasises the link between stigma and discrimination, signalling that discrimination is a necessary aspect of stigma. However, others have stressed that stigma may occur without discrimination as a constituent component. Individuals exposed to stigma may e.g. have a negative self-perception and thus restrict themselves of or avoid making use of services — including healthcare services — even though direct discrimination is not on the agenda.²¹ Consequently, stigmatisation may be an impediment for the realisation of human rights such as the right to health.

Drivers of stigma can be found at different levels in society. They may be associated with power relations operating in the individual, social and cultural fields and also be manifest in institutional settings. Likewise, stigma also has its drivers at a societal level, where both public policies and the actions of public authorities and the media can create or sustain stereotypes and prejudices.²²

17 E. Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon & Schuster, 1963), pp. 3-5.

18 B.G. Link and J.C. Phelan, ‘Conceptualising Stigma’, *Annual Review of Sociology* 27 (2001) 363-385 (p. 367).

19 *Ibid.*, p. 367.

20 *Ibid.*, p. 377.

21 *Human Rights, Stigmatization and Risk of Discrimination Against Specific Population Segments and Target Groups*, Report from TELL Me, submitted July 2012, pp. 14-15. Retrieved April 2014, <http://www.tellmeproject.eu/content/d16-human-rights-stigmatisation-and-risk-discrimination>.

22 Report of the Special Rapporteur on the human right to safe drinking water and sanitation, Catarina de Albuquerque, *Stigma and the realization of the human rights to water and sanitation*, A/HRC/21/42, 2012, paras. 18-21.

Therefore, it is important to pay attention to the potentially stigmatising role of public health policies.

4.2 *Public Health and Stigmatisation*

Stigmatisation is not foreign to public health. In his thought-provoking article on stigma and public health ethics, Ronald Bayer describes how stigmatisation has been used as a public health tool historically, as well as in recent tobacco policies. When public health developed as a professional and societal field in the beginning of the nineteenth century, the stigmatisation of particular classes and races was accepted as a '...consistent byproduct of efforts to intervene'.²³ Although there was some concern in the public health community regarding stigma, there were also proponents of stigmatisation advocating, for example, using shame to convince parents to have their children vaccinated or 'syphilisophobia' in the fight against venereal diseases.²⁴

The HIV/AIDS epidemic provoked moral concern for stigmatisation, but according to Bayer, this cannot be seen as a general shift in public health attitudes to stigma. For example, the anti-tobacco policies that have been developed gradually since the 1960s showed no restraint in the use of stigma. Bayer describes how the evidence for health risks associated with passive smoking turned smoking into an environmental health issue, allowing anti-tobacco advocates to 'assert that, like the drunk driver, those who smoked in public were culpable for the deaths of innocents'.²⁵ According to Bayer, it seems that, in contrast to HIV/AIDS, where stigma was seen as an impediment to the realisation of public health policies, stigmatisation was considered to be an efficient public health tool in the fight against smoking.

Based on experience from the anti-tobacco arena, Bayer sets out to ask why it should not be ethically justified to use stigmatisation if it can be instrumental in changing personal behaviour and subsequently reducing the burden of disease and premature mortality. Referring to Link and Phelan's observation that there are various degrees of stigma, he argues that it may be ethically justified to use weaker degrees of stigmatisation based on a yardstick of proportionality, and he lists a number of empirical questions which must be considered: 'What is the pattern of morbidity and mortality that is the object of concern? Is it the consequence of other-regarding or self-regarding acts? What evidence is there that stigma may affect behaviours and hence reduce disease,

²³ Bayer, *supra* note 13, p. 465.

²⁴ *Ibid.*

²⁵ *Ibid.*, p. 467.

suffering and death? What can be anticipated in terms of the severity, extent and duration of the suffering that the stigmatized will be compelled to bear?"²⁶ Consequently, he opens the door for a discussion of the conditions under which use of stigmatisation in public health may be ethically justified.

4.3 *Stigmatisation, Health and Human Rights*

Bayer's analysis takes as its starting point public health and public health ethics, but stigmatisation could also be discussed from a human rights perspective. If we consider Goffmann's definition of stigma as a process of dehumanising, degrading, discrediting and devaluing people in certain population groups, it is obvious that stigma has human rights implications.²⁷ If there is a perception that the stigmatised person is different from us, not quite human, it is easier socially to justify discrimination and interferences with basic rights. The history of human rights bears witness to the consequences of dehumanising and alienating individuals and groups of individuals. Exactly such policies have been used by the totalitarian regimes to foster support for and justify the discrimination and other severe human rights violations against various population groups. Hence, it is not surprising that a number of human rights instruments are concerned with stigmatisation or the results of stigmatisation, such as discrimination.

With regard to the right to health, HIV/AIDS, as noted above, provoked human rights concerns over stigmatisation. The UN General Assembly has repeatedly adopted declarations on commitments to eliminate HIV/AIDS, which stress the need to combat stigma, discrimination and violence against individuals affected by HIV and their families.²⁸ In a broader context the UN Committee on Economic, Social, and Cultural Rights explicitly addresses the link between health and stigmatisation in its General Comment no. 20 on non-discrimination in economic, social and cultural rights. It is emphasised that States often refer to protection of public health as a justification for restricting human rights based on health status (e.g. HIV status), and that many of such restrictions are discriminatory. The General Comment further stresses that 'States parties should also adopt measures to address widespread stigmatisation of persons on the basis of their health status, such as mental illness, diseases such as leprosy and women who have suffered obstetric

²⁶ *Ibid.*, p. 470.

²⁷ Goffmann, *supra* note 17.

²⁸ UN General Assembly, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, 65/277, 10 June 2011.

fistula, which often undermines the ability of individuals to enjoy fully their Covenant rights'.²⁹

In contrast to General Comment no. 20, which explicitly touches upon the risk of stigma based on health status, the Committee's General Comment no. 14 on the right to the highest attainable standard of health has its focus more narrowly on risk of discrimination in realising the right to health, especially for vulnerable groups such as women, children and persons with disabilities.³⁰ Such discrimination could be the result of foregoing stigmatisation, and in that sense, General Comment no. 14 could be said to pay attention to stigmatisation. However, there are no special reflections on this issue including on how States Parties should be aware of and tackle risk of stigma. In this respect, a recent report issued by the UN Special Rapporteur on the human right to safe drinking water and sanitation could serve as inspiration.³¹ The report, which is concerned with stigma and realisation of the human right to safe drinking water and sanitation, aims at analysing stigmatisation in a human rights context. Stigma is described as a 'deeply engrained social phenomenon that not only disadvantages entire population groups, but often results in serious human rights violations', and the Special Rapporteur emphasises that 'Situating stigma in the human rights framework is essential for identifying the obligations of the States Parties and establishing accountability'.³² On this basis she examines the effects of stigma on dignity, non-discrimination and equality, the right to privacy, the prohibition of inhuman and degrading treatment, and the right to water and sanitation. The report illustrates that stigma is important from a human rights perspective, and the human rights aspects identified by the Special Rapporteur (apart from the right to water and sanitation) could also serve as indicators for a human rights assessment of public health policies in the area of obesity prevention.

States are under an obligation to respect, protect and fulfil the right to health as well as other health-related rights, and stigmatisation may both hamper an individual's right to health and other related rights, such as the right to privacy, the right to non-discrimination and the right not to be exposed to inhu-

29 UN Committee on Economic, Social and Cultural Rights, General Comment No. 20, *Non-Discrimination in Economic, Social and Cultural Rights* (Art. 2, para. 2), U.N. Doc. E/C.12/GC/20 (2009), para. 33.

30 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, *The right to the highest attainable standard of health* (Art. 12), U.N. Doc. E/C.12/2000/4 (2000).

31 Report of the Special Rapporteur on the human right to safe drinking water and sanitation, De Albuquerque, *supra* note 22.

32 *Ibid.*, para. 43.

man and degrading treatment. Therefore, it is important that governments are aware of and take action against the stigmatisation of individuals, including individuals suffering from obesity.

5 Human Rights Assessment of Public Health Policies Addressing Obesity

5.1 *Introduction to Selected Policies and Methodology*

To study how public health policies comply with human rights and especially how stigmatisation is addressed in such policies, four public health policies on obesity have been chosen for examination here; two Europe wide policies (EU and WHO Europe) and two national ones (Denmark and England).

The WHO's European Charter on Counteracting Obesity was drafted by a UN institution which has the specific task of promoting population health.³³ The WHO has issued a number of policies regarding non-communicable diseases,³⁴ and the Charter was chosen because it is targeting obesity in Europe and therefore is suitable to compare with policies of the EU and EU Member States. As a member of the UN family, the WHO is linked to a broader human rights framework, and it has actively worked to create awareness of the damaging effects of stigmatisation with regard to HIV/AIDS.

The EU has a much broader scope than WHO, and the EU's focus on health is embedded in a wider context which also includes the functioning of the internal market.³⁵ Although the EU has limited competence over national healthcare systems, issues such as labelling of food products, health claims and product and agricultural policies fall within its remit, and so do other initiatives in the field of educational and regional policy as well as media policy. Among other actions, the EU Commission has issued a White Paper with a strategy on nutrition, overweight and obesity.³⁶

33 WHO-Europe, *European Charter on counteracting obesity* (2006).

34 See e.g. WHO, *supra* note 7; and WHO, *Global strategy on diet, physical activity and health* (2004).

35 A. Faeh, 'Obesity in Europe: The Strategy of the European Union from a Public Health Law Perspective', *European Journal of Health Law* 19 (2012) 69-86.

36 EU, *White Paper on A Strategy for Europe on Nutrition, Overweight and Obesity related health issues*, COM (2007) 279 final, (2007). See also EU, *Green paper 'Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases'*, COM (2005) 637 final (2005).

England and Denmark have recently issued special policy papers addressing obesity.³⁷ England has been chosen because it has one of Europe's highest obesity rates, whereas Denmark has one of the lowest.³⁸ The policies have been carefully examined with a view to:

- identify whether the policies explicitly or implicitly demonstrate awareness of the right to health and other health-related rights
- identify whether the policies explicitly or implicitly demonstrate awareness of issues related to stigmatisation
- identify examples and patterns where the policies could be seen, whether intentionally or unintentionally, as creating or sustaining elements of stigmatisation.

5.2 *Right to Health and Other Health-Related Rights*

In assessing the awareness in the policy papers regarding the right to health and other health-related rights, the UN Committee on Economic, Social and Cultural Rights, General Comment no. 14 on the right to the highest attainable standards of health, will serve as a basis.³⁹ It contains a comprehensive and broad approach to the right to health, which is necessary when dealing with health promotion with regard to conditions such as obesity. The General Comment emphasises the obligations governments to respect, protect and fulfil the right to health, which indicates that the main responsibility for population health rests on the governments, and it sets out to clarify and exemplify the obligations of governments in further details.⁴⁰ The clear focus on governmental responsibility in the General Comment is, however, moderated a bit. Accordingly, para 8 stress that the right to health, '... is not to be understood as a right to be *healthy*', and it follows from para 9 that the state

37 HM Government, *Healthy Lives, Healthy People: A Call to Action on Obesity in England* (2011); and Danish Health and Medicines Authority, *Forebyggelsespakke: Overvægt (Health promotion package: Overweight)*, (2013). The Danish policy on obesity is part of a more comprehensive health prevention package with a number of other specific policy papers in areas such as mental health, physical activity and alcohol. An English resume is available on this link: <http://sundhedsstyrelsen.dk/publ/Publ2013/02feb/HealthPromoPacksDK.pdf> (retrieved April 2014).

38 WHO, *Country profiles on nutrition, physical activity and obesity in the 53 WHO European Region Member States*, (2013). Retrieved April 2014, <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/country-work>.

39 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, *The right to the highest attainable standard of health (Art. 12)*, U.N. Doc. E/C.12/2000/4 (2000).

40 *Ibid.*, paras. 30-45.

cannot ensure good health or protect the individual against all possible causes of ill health, as ‘...genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual’s health’. Therefore, the right to health must be understood as a ‘...right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health’. General Comment no. 14 also emphasises the importance of non-discrimination and equal treatment (para 18) and of paying special attention to vulnerable groups such as women, children and adolescents, older persons, person with disabilities and indigenous peoples.

In assessing the human rights awareness of public health policies other health-related rights must also be taken into consideration (para 3). These include the right to life, the right to privacy and self-determination, the right not to be exposed to degrading and inhumane treatment and the right to non-discrimination.⁴¹

The *WHO Charter on Counteracting Obesity* does not explicitly mention the right to health or other health-related rights, but implicitly it recognise the right to health. It emphasises throughout the charter the responsibility of governments, regions and municipalities to develop health-promoting policies and actions with a broad focus,⁴² and it also stresses that it is not acceptable to hold individuals alone responsible for their obesity.⁴³ Furthermore, the charter is aware of the needs of vulnerable groups,⁴⁴ and it emphasises the role of health systems in providing diagnosis, screening and treatment for those who are already overweight and obese.⁴⁵ This attitude complies with the broad perception of the right to health and State responsibilities laid down in General Comment no. 14, as well as with the emphasis placed on vulnerable groups in the General Comment.

The EU’s *White Paper on a Strategy for Europe on Nutrition, overweight and obesity* makes no mention to the right to health or other health-related rights,⁴⁶ but like the WHO Charter, it appears implicitly to recognise the right to health

41 Toebes, *supra* note 5.

42 WHO, *supra* note 33, para 2.4.

43 *Ibid.*, para. 2.3.3.

44 *Ibid.*, paras. 2.3.7-2.3.8.

45 *Ibid.*, para. 2.4.1.

46 The absence of references to the right to health in Article 35 of the EU Charter on Fundamental Rights is surprising, as the Charter could sustain the policy in this area. However, it may be explained by the fact that the Charter first became part of EU black letter law after the Lisbon Treaty came into force in 2009, and thus after the release of the white paper.

in emphasising the broad responsibility of both the EU and its Member States for developing vertical as well as horizontal policies.⁴⁷ In contrast to the WHO Charter, it places more emphasis on individual responsibility, stressing that 'the individual is ultimately responsible for his lifestyle, and that of his children', but it adds 'while recognising the importance and the influence of the environment on his behaviour'.⁴⁸ The White Paper also stresses the importance of socio-economic and environmental factors, thus acknowledging both the social determinants of health and the wider environmental context. This also includes awareness of the informational environment (nutrition labelling, regulation of health claims, advertising (especially if aimed at children)), as well as the role of schools and sports association in making healthy food options (e.g., school fruit schemes) and physical activity available.⁴⁹ In general, the EU White Paper complies with the broad approach and responsibilities laid down in General Comment no. 14. Compared to the WHO Charter, less attention is paid to vulnerable groups, although children are mentioned several times as a group requiring special attention.

Looking at the national policies, the *Call to Action on Obesity in England* represents a very comprehensive policy. Along the same line as the two European policy papers, it does not specifically address the right to health and other health-related rights, but throughout the paper the responsibility of the NHS and local governments to provide a comprehensive and integrated range of interventions targeting both the prevention of obesity and various treatment options is mentioned.⁵⁰ The paper also acknowledges that a broad focus is needed, including both socio-economic and environmental actions, and it assigns responsibility for these to various actors, including private business. Compared to the two European policy papers — and especially the EU white paper — the English call to action more explicitly addresses separate concerns for specific groups that are more exposed to obesity than others, such as children, persons of lower socio-economic status, certain ethnic groups and persons with disabilities and mental disorders. In paying attention to these groups, it acknowledges the importance of focusing on vulnerable groups and it also explicitly pays attention to the importance of using less intrusive measures in referring to the Nuffield Council on Bioethics intervention ladder.⁵¹

47 EU, *supra* note 36, Section 1.

48 *Ibid.*

49 *Ibid.*, Section 4.

50 HM Government, *supra* note 37, e.g. Sections 4.3 and 4.11-4.14.

51 *Ibid.*, Section 3.13. The 'intervention ladder' reflects various degrees of intrusiveness in directing and controlling individuals' choice, see Nuffield Council on Bioethics, *Public health: ethical issues*, 2007.

Seen as a whole, the English policy paper complies with the broad approach to the right to health and the governmental responsibilities laid down in General Comment no. 14, specifically paying attention to vulnerable groups and demonstrating its awareness of other health-related rights, such as the rights to privacy and self-determination.

Like the other policies, the *Danish Health Promotion Package* on obesity does not express a commitment to the right to health or other health-related rights. It is, however, aware of the social determinants of health and a note that overweight is not exclusively an individual responsibility but also a societal concern.⁵² Furthermore, it is also sensitive towards the special needs of vulnerable groups, highlighting children, pregnant women, migrants, person with mental disorders or physical and mental disabilities, and socially and educationally disadvantages persons as more susceptible to overweight than other parts of the population.⁵³ The Danish policy is, however, not as clear as the English policy and the WHO Charter in emphasising the obligations and responsibilities of the government and municipalities. Compared with the other policy papers, the Danish health promotion package also pays less attention to the wider environmental context. Its recommendations are primarily directed at changing individual behaviour, and although it recognises the importance of creating 'culture and surroundings' supporting healthy eating habits and physical activity, it does not give more specific recommendations on these broader environmental issues compared to what is reflected in the other policies. This may partly be explained by the fact that this is just one among several prevention packages, others of which are targeting environmental issues such as urban planning. Like the English call for action, the Danish policy has also clear focus on various vulnerable groups and much more explicitly addresses ethical concerns regarding stigmatisation and discrimination than the other policies, thus paying some attention to other health-related rights.

5.3 *Stigmatisation: Avoidance and/or Fostering*

In looking for both awareness of the avoidance of stigma and possible examples of fostering stigmatisation, I shall use both Ervin Goffmann's definition of stigma as reducing the sufferer 'from a whole and usual person to a tainted, discounted one' and Link's and Phelan's components of stigmatisation which include 'labelling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows the components of stigma to unfold'.

WHO's *Charter on Counteracting Obesity* only explicitly mentions stigma when it emphasises that 'Any stigmatisation or overvaluation of obese people

52 Danish Health and Medicines Authority, *supra* note 37, p. 7.

53 *Ibid.*, p. 9.

should be avoided at any age'.⁵⁴ Apart from this statement, the Charter does not mention elements that explicitly relate to the components of stigma. However, it does emphasise that individuals alone should not be held responsible for their obesity, and the wording is careful to point to various social, economic and environmental determinants, which shape the options for individuals in living more healthy lives.⁵⁵ Responsibility for curbing the obesity curve is primarily placed on the shoulders of governments together with other stakeholders.⁵⁶ In placing responsibility on other actors than the individual, it avoids labelling and categorising overweight and obese persons as blameworthy. Consequently, the Charter does not explicitly aim at combatting stigmatisation, but on the other hand it does not seem to foster stigma.

The *EU White Paper on a Strategy for Europe on nutrition, overweight and obesity* does not mention stigmatisation or pay attention to the risk of stigmatisation. Compared to the WHO Charter it places more responsibility on the individual, but at the same time it carefully points to the broad responsibility of the EU and its Member States, thus generally avoiding exposing individuals as blameworthy. However, in one instance it notes that the Commission will 'finance a study looking at the relationship between obesity and socio-economic status with a view to considering the most effective interventions to *tackle* those in low socio-economic groups' (my italics).⁵⁷ The wording suggests that persons from lower socio-economic groups need to be tackled (in contrast to other and more responsible persons), and it could be seen as an example of labelling, stereotyping and separation in Link's and Phelan's understanding.

The *English Call to Action on Obesity* policy explicitly refers to the risk of stigmatisation, and it also stresses that overweight and obesity contribute to low self-esteem.⁵⁸ However, at the same time it is the policy paper, which most explicitly relates individual behaviour to the economic costs for society and employers.⁵⁹ The costs are even mentioned right after the risk of low self-esteem in the foreword and the executive summary, possibly conveying the message that the individual must take responsibility both for having low self-esteem and for the economic costs for society as a whole. As stressed in the foreword, 'At a time when our country needs to rebuild our economy, overweight and obesity impair the productivity of individuals and increase

54 WHO, *supra* note 33, para. 2.4.10.

55 *Ibid.*, para. 2.1.

56 *Ibid.*, para. 2.4.6-2.4.7.

57 EU, *supra* note 36, p. 8.

58 HM Government, *supra* note 37, e.g. Sections 1.16 and 1.18.

59 *Ibid.*, e.g., Sections 1.23-1.27.

absenteeism'.⁶⁰ The wording may be received by some as suggesting that overweight and obese persons are responsible for the slow economic recovery. In other aspects too, the paper teeters on the edge of stigmatisation. From a health and human rights perspective, it is positive that it pays attention to vulnerable groups such as persons with lower socio-economic status, learning disabilities or mental health problems. However, the paper remarks that many overweight and obese persons 'also have other lifestyle risks (such as) drinking above recommended limits or smoking' and that they live in communities 'where other social issues such as lower educational attainment, poor housing or crime, are heightened'.⁶¹ Even though such observations are evidence-based, they may serve to label and stereotype overweight and obese individuals, thereby separating 'them' from 'us'. Finally, the paper in many ways strives to promote collective responsibility and the empowerment of individuals. However, at the same time it also makes distinctions between those who are in a position to help and those who need help, thus creating a sense of 'them' and 'us'.

The *Danish Health Promotion Package* on obesity is explicitly concerned with stigmatisation. It addresses the ethical challenges and refers to mobbing, stigmatisation and discrimination as problems facing overweight and obese individuals in healthcare services, employment relations and educational systems, as well as in private life. It also emphasises that the categorisation of overweight and obese citizens as 'abnormal' in public health policies should be avoided and instead a broad concept of normality should be applied.⁶² However, irrespective of this clear and explicit commitment to avoid categorisation and stigmatisation, the prevention package still uses the notion of normality when throughout the paper the phrase 'normal weight' is used several times, thus sending the message that being overweight is outside the scope of normality.⁶³ Furthermore, it also uses the expression 'detecting' persons at risk of being overweight and obese. Hence, it is a task for various professional groups (e.g. social assistants, community nurses and GPs) in different settings to detect at-risk individuals in all population groups (children, adults and the elderly). The wording present a risk of dehumanising individuals (turn them into 'objects' instead of 'subjects') and exhibiting such persons as 'others' separated from 'us'. Groups with higher risks are also explicitly mentioned (ethnic minority background, mental illness, learning disorder, psychical disability,

⁶⁰ *Ibid.*, pp. 3, 5.

⁶¹ *Ibid.*, Section 2.14.

⁶² Danish Health and Medicines Authority, *supra* note 37, p. 7.

⁶³ S. Vallgård, 'Ethics, equality and evidence in health promotion Danish guidelines for municipalities', *Scandinavian Journal of Public Health* (2014), online version 7 March 2014.

the unemployed, persons on social benefits and persons with lower levels of education), which may again present a risk of labelling, stereotyping and separation.

6 Discussion and Conclusion

The four policy papers are all concerned with finding a suitable strategy to curb one of the major public health challenges. In this Section, I will discuss how the policies could be assessed from a health and human rights perspective.

There are three important aspects, which must be included in a human rights assessment of the four policy papers. The first dimension is concerned with recognition of the right to health as an aspect of public health policies. It is important to perceive public health not only as concerned with population health but also with realising the individual's right to health. Individuals are entitled to be recognised as persons with individual health needs. Public health policies addressing overweight and obese persons as a 'group' or 'category' and not as individuals could be examples of non-human rights sensitive policies.⁶⁴ Similarly, an 'aggressive' public health policy may also lead to fear and avoidance among the targeted persons, as was witnessed in regards to some HIV/AIDS policies.⁶⁵ This may constitute an impediment for the enjoyment of the right to health.

The second aspect is concerned with the limitations imposed by human rights law on public health efforts. Public health measures must respect the individual's human rights, including the right to private and family life, self-determination, right to non-discrimination and right not to be exposed to inhumane and degrading treatment. As an example, taking an obese child away from his/her parents could be a violation of both the child's right to self-determination and family life as well as the parents right to family life.

Where the two first aspects are concerned with how human rights are directly impacted by public health policies, the third aspect focuses on situa-

64 See as an example of the importance of looking at the individual and not only at the individual as part of a group ECtHR *Kiyutin v. Russia*, application no. 2700/10. This case was concerned with a HIV positive non-Russian national who were denied residence permit in Russia where his wife and child lived. According to Russian law foreign nationals residing in Russia should be denied residence if they were HIV positive. In para. 68 the Court observes that the assumption that HIV-positive non-nationals would engage in specific unsafe behaviour '... amounts to a generalisation which is not founded in fact and fails to take into account the individual situation, such as that of the applicant'.

65 See *supra*, Section 3.

tions where public health policies may indirectly negatively impact enjoyment of human rights. If, e.g. public health policies intentionally or unintentionally stigmatise individuals and expose them as dangerous or blameworthy, it may lead to discrimination in e.g. employment and social security relations or healthcare and educational settings.⁶⁶

The analysis shows that all policy papers almost exclusively take a classic public health approach with only little consideration for human rights issues and concerns. The right to health is not mentioned, which is surprising, as this could enhance the emphasis on governments' and public actors' obligations which are particularly stressed in the WHO Charter on counteracting obesity, the EU white paper on nutrition, overweight and obesity, and the English call to action. Other health-related rights are not explicitly referred to and only touched upon indirectly in the English call to action and the Danish health promotion package. The English call to action on obesity shows the greatest awareness of human rights and is thus the paper that demonstrates the most integrated approach to public health and human rights. It is clear in placing responsibilities on the government and municipalities in promoting conditions under which individuals can lead a healthy life, and it refers to the Nuffield Council's intervention ladder hereby demonstrating awareness of central human rights issues such as the right to privacy and self-determination. The Danish health promotion package on obesity pays attention to ethical challenges such as stigmatisation and discrimination, but it seems more like an add-on to a classic public health approach and is not integrated throughout the paper. Overall, the four policy papers only to a limited extent integrate human rights law in public health policies. The right to health as an individual right is not very visible and the human rights limitations to public health interventions are scarcely addressed. Finally the risk that certain public health policies may impede individuals from enjoying the right to health is not reflected.

The lack of integration between human rights and public health may also serve to explain the limited focus demonstrated in the policy papers on stigmatisation and the risk of discrimination caused by such stigmatisation. The English and the Danish policies both refer to stigma and discrimination against overweight and obese persons in various settings, but only the Danish promotion strategy address stigma caused by public health interventions. The Danish policy has a special section on ethical challenges, where — among other

66 W.A. Bogart, 'Law as a Tool in "The War on Obesity": Useful Interventions, Maybe, But, First, What's the Problem?', *Journal of Law, Medicine & Ethics* (41)1 (2013) 28-41; A. Kirkland, 'Think of the Hippopotamus: Rights Consciousness in the Fat Acceptance Movement', *Law & Society Review* (42)2 (2008) 397-431.

issues — the risks of both stigmatisation and discrimination caused by public health interventions are briefly addressed. However, as mentioned above, the ethical reflections are not streamlined throughout the policy paper. In contrast, the Danish policy itself exhibits examples of wording and approaches that represent the components of stigma as identified by Link and Phelan. As exemplified above in section 5.3 both the Danish and the English policy papers display a number of examples of labelling, categorisation, stereotyping and separation, which may have a stigmatising and dehumanising effect on overweight and obese individuals. This is a concern from a human rights perspective, as it can be seen as reflecting lack of respect for dignity, and furthermore may fuel stigma of overweight and obese individuals, which may subsequently lead to discrimination or impeding individuals from enjoying their human rights due to low self-esteem.

Several research studies confirm that this is not only a theoretical concern and that stigma and discrimination of overweight and obese persons takes place in e.g. employment relations, healthcare services and educational settings.⁶⁷ Such examples of discrimination may, to the extent they qualify for protection in the corpus of human rights law, amount to violation of basic human rights.⁶⁸

Bayer opens up a discussion on ethical justification for the use of stigma as a public health tool in the fight against obesity based on a proportionality assessment of possible measures and interventions.⁶⁹ In this assessment

67 R.M. Puhl and C.A. Heuer, 'The Stigma of Obesity: A Review and Update', *Obesity* 17(5) (2008) 941-964; Bogart, *supra* note 66; Kirkland, *supra* note 66.

68 Whether human rights law provides protection against discrimination of overweight and obese individuals is not subject for examination in this article. It would need further and more focused and elaborated analysis of individual human rights (e.g. the right to health, right to work, right to education, etc.), including the extend to which obesity could be considered a disability protected by the UN Covenant on the Rights of Persons with Disabilities. In ECtHR *Kiyutin v. Russia*, application no. 2700/10, the European Court of Human Rights came to the conclusion that '...distinctions made on account of one's health status, including such conditions as HIV infection, should be covered — either as a form of disability or alongside with it — by the term 'other status' in the text of Article 14 of the Convention' (para. 57). This indicates that overweight and obesity — if considered a disability or health status — potentially may be covered by human rights non-discrimination provisions. See also UN Committee on Economic, Social and Cultural Rights, General Comment No. 20, *Non-Discrimination in Economic, Social and Cultural Rights* (Art. 2, para. 2), U.N. Doc. E/C.12/GC/20 (2009), which mentions 'health' as an example of 'other status' (para. 33).

69 Bayer, *supra* note 13, p. 470.

empirical evidence regarding the suffering and severity of conditions caused by overweight and obesity is of importance, and so is the evidence that stigma may affect behaviours and reduce such consequences. The severity, extent and duration of the suffering, which the stigmatised person will have to bear, must also be taken into consideration.

This kind of proportionality reasoning is familiar for human rights thinking, and the question is, how use of stigma as a public health tool would be assessed from a human rights perspective.

If we consider a hypothetical situation where public health policies deliberately intervened in the rights of overweight and obese persons (e.g. excluded them from access to specific healthcare services or education) with the aim of encouraging individuals to comply with public health policies, this would obviously need justification. In this situation a human rights assessment would look critically at the possible justification for intervention. Consequences of overweight and obesity may be very serious both seen from a public health and an economic perspective and may be a legitimate aim. However, to pass the proportionality test very robust evidence that stigmatisation is a suitable measure to avoid these consequences must be demonstrated, and it must furthermore be proved that less intrusive measures are not available. In this regard the complex causes of obesity must be taken into consideration. In the proportionality assessment significant weight will, in addition, be put on the severe impact of individuals caused by stigmatisation. This could in itself speak in favour for a very limited scope for the States margin of appreciation. In the *Kiyutin v. Russia* case, the European Court of Human Rights stressed that:

If a restriction on fundamental rights applies to a particularly vulnerable group in society that has suffered considerable discrimination in the past, then the State's margin of appreciation is substantially narrower and it must have very weighty reasons for the restrictions in question.⁷⁰

Following this line of argument, there are good reasons for not accepting such a hypothetical policy even though stigmatisation turned out to be an efficient public health tool.

If we turn to the four policies analysed, they do not themselves initiate formal discriminatory practices, which involves violation of human rights. However, to the extent they contribute to stigmatisation of overweight and obese individuals they may — indirectly — fuel substantive discriminatory practices which may expose individuals to human rights violations in various

⁷⁰ ECtHR, *Kiyutin v. Russia*, application no. 2700/10, para 63.

settings. They may also lead to intimidation or self-loathing and thereby impeding individuals from enjoying the right to health or other rights. In this sense there are good grounds for concern.

Consequently, a human rights compliant public health policy should not only strive to ensure that governments live up to the duty of ensuring the individual's right to health but also take action to prevent and combat human rights abuses of overweight and obese individuals caused by stigmatisation. This demonstrates the importance of integrating a human rights approach in public health policies.